Documentation of Health, Systemic or Mobility Related Disability

To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide current documentation of their disability. This documentation should provide information regarding the onset and severity of the disability, as well as describe how it interferes with educational achievement. In order to establish that an individual is covered under ADA and Section 504 of the Rehabilitation Act of 1973, documentation must demonstrate that the individual has a disability and that it substantially limits some major life activity, including learning. The documentation must show how the disability impacts the major life activity of learning, and must support the request for accommodations.

The student named below has applied for services from the Accommodation Services Office at Lakeshore Technical College. In order to provide reasonable and appropriate services for students with health, systemic or mobility related disabilities, current and comprehensive information documenting the functional impact of the disability is required. This form is intended to assist clinicians in providing sufficient information so that eligibility for services can be determined. The information you provide will not become part of the student's educational records and will be kept in the student's confidential file in the Accommodation Services Office.

The provider(s) should attach any reports that provide additional related information. ***If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted as documentation instead of this form.***

Please Print Legibly

Student Name: _____

Date Completed: _____/_____/_____ Student's Date of Birth _____/_____/_____

1. What is the diagnosis?

   _____

   _____

   _____

2. Date of diagnosis: _____
3. When did you last see the student/patient? _____
4. Is the student/patient currently under your care? _____ Yes _____ No

Accommodation Services
Phone: 920.693.1120 (Nicole) | 920.693.1274 (Christi)| 711 (Wisconsin Relay)
Email: nicole.yang@gotoltc.edu | christi.leonhard@gotoltc.edu
Fax: 920.693.1827 | Web: www.gotoltc.edu

5. What is the severity of the condition? Please check one:

☐Mild ☐Moderate ☐Severe

Explain Severity: _____

_____

6. Describe the progression/history of this condition, if applicable (historical summary).

_____

_____

_____

_____

_____

7. Describe the prognosis and the anticipated duration of the condition.

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8. Major Life Activities Assessment – A student must have a substantial limitation in a major life activity to receive accommodations at the post-secondary level.

   Please check which of the following major life activities are affected because of the disability. Indicate severity of limitations.

Life Activity	Negligible	Moderate	Substantial	Unknown	Not Applicable
Speaking					
Hearing					
Seeing					
Breathing					
Walking					
Standing					
Reaching					
Lifting					
Sitting					
Caring for Oneself					
Performing Manual Tasks					
Working					
Interacting With Others					
Sleeping					
Learning:					
• Reading					
• Writing/Spelling					
• Calculating					
• Listening					
• Thinking					
• Concentrating					
• Memorizing					
Other:					

9. Describe how this medical condition may result in specific functional limitations in an academic setting (e.g., problems sitting for long periods of time; unable to type for more than 10 minutes out of 60 minutes; unable to walk more than 50 feet without fatigue).

_____

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_____

10. List current medication(s) that may impact the student in the educational setting, and what impact they may have.

_____

_____

11. If the student is currently undergoing medical treatment, please describe and indicate how the treatment might affect the student in a post-secondary setting.

_____

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_____

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_____

12. Are there any situations or environmental conditions that might lead to an exacerbation of the condition?

_____

_____

_____

13. State specific recommendations regarding academic accommodations for this student, and the rationale as to why these accommodations/services are warranted based upon the student's functional limitation. Indicate why the accommodations are necessary.

_____

_____

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_____

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14. If any co-morbid conditions exist, please describe.

_____

_____

_____

_____

Provider Information

Name (Please Print):		
Medical Specialty:	**License #:**	
Address:		
Phone:	**Email:**	
Clinician's Signature:		**Date:**

Please mail or fax this completed form and any additional information to:

Accommodation Services Office
Lakeshore Technical College
1290 North Avenue
Cleveland, WI 53015

Fax: (920) 693-1827